

**GETTING IT RIGHT:
ISSUES FOR MEDICARE REFORM**

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Mr. Chairman and members of the Committee: Thank you for inviting me here today to testify on the important question of how to improve the Medicare program.

Normally when I provide testimony on Medicare I focus on the impacts on beneficiaries and how to improve the program so as to fairly meet its goals. And indeed, that will be a major focus of this written statement. However, I also feel compelled to begin with a number of comments that reflect my training as a traditional economist. I am concerned that in the name of “cost savings” and “efficiency,” a number of changes in Medicare are being proposed that violate basic economic principles.

If competition is to be promoted and relied upon to generate greater efficiency, a number of conditions should be met. The success of any “competition-based” reform plan will depend on how the following issues are addressed.

First, **the playing field must be level.** How can we test whether private plans are a better deal for beneficiaries than traditional Medicare if the legislation provides extra subsidies or benefits to these private plans? If private plans are more efficient as claimed, then the best test is to let the market work.

Second, **price competition only arises when products are very similar so that consumers can compare prices.** If, in the case of prescription drugs, for example, the cost sharing structure and the formulary (i.e. what drugs will be covered under what conditions) vary, it will become very difficult for consumers to make good choices. In the case of preferred provider organizations, choices are even more difficult because of the broad range of ways in which coverage can vary. How does a consumer trade off hospital co-payments with varying drug benefits with limited access to providers, for example?

A third and related issue is that **reliable information is needed when plans vary in coverage and access to care.** But, at present, much of the information claiming that PPOs allow access to any doctor or hospital is misleading. Only in-network providers likely will be available at reasonable rates. A number of studies point out how limited some of the FEHBP networks can be. Further, even savvy consumers cannot find out what it will cost them to go out-of-network. These are details, but essential to making good choices.

Fourth, if we expect consumers to plan for their expenses and be good budgeters, **a drug plan that contains a “gap” or “donut hole” makes no sense.** If the government contribution is high for the first part of the year when a consumer is purchasing drugs, he or she is likely to come to expect that. But the dirty little secret of a gap is that, for a person with expenditures of, say, \$5000 per year, the plan would contribute to costs from February to September, but then stop paying any of the drug costs come October. There will be a lot of confused and angry consumers in line at their local pharmacies in the fall.

Fifth, **any plan reforming Medicare needs to contend with the potential for “market failure.”** When conditions, such as lack of knowledge by consumers, competitive advantages by some suppliers over others, incentives for risk selection that can be only poorly addressed, or the presence of social goals that the market is not designed to meet exist, don’t expect markets to work well. The social goals will not be achieved, and there may be little efficiency or cost savings arising from the market.

As someone concerned about social goals, the rest of my testimony attempts to explain why I have concerns about the details that seem to be part of the proposal the Senate will be debating, and, on a broader scale, about the optimism that a private sector approach can make a serious dent in the issues facing Medicare now and in the future. Finally, on a practical level, more attention needs to be placed on improving the traditional program that now serves nearly nine out of every ten beneficiaries and will continue to have a disproportionate number of enrollees. Stoop loss protections and incentives for care coordination ought not be limited to PPOs.

Difficult challenges arise in deciding how to reform Medicare to meet future demands that an aging population and rising health care costs inevitably will place on the system. Costs to society for the health care of older and disabled Americans will rise over time, both in dollars and as a share of our economy. Market forces do not represent the magic bullet that will solve all of Medicare’s problems. Nonetheless, much of the debate on Medicare’s future has focused on broad restructuring proposals. This restructuring would rely upon contracting with private insurance plans, which would compete for enrollees. In addition, a drug benefit, representing an important promise made to beneficiaries, is also a critical part of the debate.

These changes could profoundly affect Medicare’s future, but as yet there are few details on which to base an informed debate. I attempt to raise here a number of issues that ought to be carefully considered before making a massive change in this program. The second half of my testimony focuses on broader philosophical issues regarding changes in Medicare.

CONCERNS ABOUT THE DETAILS KNOWN SO FAR

The initial summary released about the Senate Finance plan indicates that a number of improvements have been made over the earlier approach outlined by the Administration. Providing the same actuarially equivalent drug benefits to all Medicare beneficiaries regardless of what plan they choose is a major advance in fairness. And the low income protections have been expanded over what has been proposed in the past. Nonetheless, a number of elements remain troublesome. The following is a list of such issues, not intended to be exhaustive, but rather illustrative of the care that is needed before putting together any final legislation. Each of these issues ought to be discussed at considerable length and supplemented with details not available at this time.

- **Low income beneficiaries.** Treating low income Medicare beneficiaries who are also participating in the Medicaid program exclusively through the means-tested Medicaid program would make them “second class citizens.” One of Medicare’s enormous strengths is its universal treatment. The 17 percent of beneficiaries who are dually eligible should be at the top of the list of concerns for reform and not shunted to the bottom.
- **Who is considered in need of special help.** While the suggested drug benefit offers substantially better drug benefit for those who it would cover, the level of income necessary to obtain protection is very low. At 150 percent of poverty, a drug cost of even \$2000 can be catastrophic. But that is where this plan’s help for those with low income would end. As Table 1 indicates, drug costs for someone with modest incomes but above the protected level would quickly become exorbitant even if that person bought into the drug benefit.
- **The “gap” or “donut hole” in the drug benefit** generates major problems. It is hard to understand and reduces protection just at the time when many of those who are most in need are expecting some relief. That is, persons with chronic conditions are likely to have drug expenses in the range of \$3,000 to \$5,000. Many take several drugs every day, each of which can cost \$1,000 or more per year. This is where the growth in spending is occurring and it is these drugs that may ultimately help to lower health care costs in the future. From the early numbers released on the benefit’s structure, persons with spending between \$5,000 and \$5,500 would have to pay over two thirds of the costs of their drugs. This is a greater share than someone with \$2000 in expenditures has to pay, for example. A flat percentage contribution up to a catastrophic limit would be a fairer, simpler, and more honest way to structure a benefit. The basic problem is that \$400 billion is not enough to provide a well-designed prescription drug benefit.
- **Disadvantages of a standalone drug benefit.** Beneficiaries in traditional Medicare will be put at a particular disadvantage by the having to purchase a standalone drug benefit. For a number of reasons, separating that benefit from the rest of Medicare will make it a less efficient and hence more costly benefit. If the actuarial value is the same as that for integrated plans, traditional Medicare beneficiaries may be put at a disadvantage since more of the costs will go to administration than if it were coordinated with Medicare. And if plans are allowed to tinker with the deductibles, the formularies and other aspects of the benefit, it will be very difficult for beneficiaries to know what they are getting.
- **The Fallback Drug Benefit.** The convoluted means for assuring a drug benefit to those in traditional Medicare means that individuals cannot count on a stable and viable benefit over time. If they must change plans frequently and occasionally rely on a fallback system, beneficiaries may find themselves having to shift drugs as the formularies and other details of plans change. More stability is needed. Why not simply offer a fallback benefit through Medicare as a

standard option available to everyone? If private plans prove themselves, then beneficiaries may not use the government option. If private plans cannot compete effectively, why should special efforts be made to prop them up?

- **Subsidies to private plans.** Finally, why offer a 2 percent increase in payments to PPOs? Let private plans prove themselves as markets are meant to do without special treatment for one player or another. If any special treatment is to be given, it ought to be directed where the most vulnerable beneficiaries choose to enroll. For the foreseeable future, that is likely to be traditional Medicare. And this is particularly troublesome in an environment where the drug benefit is poorly designed because of the limits on what the Congress is willing to spend. A 2 percent payment add-on for PPOs, for example, would amount to an extra \$153 per enrollee in 2006. And if 20 percent of Medicare beneficiaries move to such plans, that will require a commitment of resources sufficient to otherwise reduce the monthly premium for all beneficiaries for a drug benefit by \$5 per month, for example.

MEDICARE VS. THE PRIVATE SECTOR

Looking back over the period from 1970 to 2000, Medicare's cost-containment performance has been better than that of private insurance. Starting in the 1970s, Medicare and private insurance plans initially grew very much in tandem, showing few discernible differences. By the 1980s, per capita spending had more than doubled in both sectors for comparable services. But Medicare became more cost-conscious than private health insurance in the 1980s, and cost containment efforts, particularly through hospital payment reforms, began to pay off. From about 1984 through 1988, Medicare's per capita costs grew much more slowly than those in the private sector. Thus, its base relative to the private sector contracted and a gap in the two growth lines shown in Figure 1 opened up.

This gap in overall growth in Medicare's favor stayed relatively constant until the mid 1990s when private insurers began to take seriously the rising costs of health insurance. At that time, growth in the cost of private insurance moderated in a fashion similar to Medicare's slower growth in the 1980s. Thus, it can be argued that the private sector was playing "catch up" to Medicare in achieving cost containment. Private insurance narrowed the difference with Medicare in the 1990s, but as of 2000, there was still a considerable way for the private sector to go before its cost growth would match Medicare's achievement of lower overall growth.

Moreover, since 1988, information on private insurance indicates substantial increases in costs being passed on to consumers. Premiums charged to employees for policies, for example, have risen twice as fast as premiums in Medicare. Deductibles and other cost sharing have also risen rapidly over time in the private insurance market.

WILL RELYING ON PRIVATE PLANS INHERENTLY LEAD TO SAVINGS FOR MEDICARE?

Some supporters of a private approach seem to assume that private plans inherently offer advantages that traditional Medicare cannot achieve. But there is no magic bullet to holding the line on the growth in health care spending. Per capita spending rises because of the growth in use of services, higher prices, or a combination of the two. Medicare's price clout is well known and documented.

So what about use of services? Studies of managed care have concluded that most of them saved money by obtaining price discounts for services and not by changing the practice of health care. Reining in use of services represents a major challenge for private insurance as well as Medicare in the future, and it is not clear whether the public or private sector is better equipped to do this. The newest type of plans suggested as an improvement for Medicare beneficiaries, preferred provider organizations (PPOs), generally obtain their savings by paying very little for any patient who goes outside the network to get care. Thus, their strategy is often one of cost shifting onto beneficiaries. This may hold down PPO premiums, but from society's standpoint, does little to help with reducing health care costs.

Private insurers are interested in satisfying their own customers and generating profits for stockholders. When the financial incentives they face are very broad (such as receiving capitated payments), private insurers respond as good business entities should. They seek the easiest ways of holding down costs in the provision of services. This indeed is what competition is all about. Cream skimming of the market serves these goals very well: Medicare overpays, and plans can both make the healthier beneficiaries they enroll very satisfied while making good profits. The problem is that this response is not good for limiting overall costs to either the federal government or to society as a whole. Thus, care needs to be taken to use the market when we understand and approve of the direction that competition will take health care delivery.

In addition, private insurers will almost surely have higher administrative overhead costs than does Medicare. Insurers need to advertise and promote their plans. They would face a smaller risk pool that may require them to make more conservative decisions regarding reserves and other protections against losses over time. These plans expect to return a profit to shareholders. All of these factors cumulate and work against private companies performing better than Medicare.

Finally, it is important to note that few private insurance companies escape problems of complexity and bureaucracy. Many patients, both young and old, find the requirements of their plans to obtain approval before getting some services, to determine which doctors and hospitals are in network and which are not, to understand the bills when they come due months later, and to use the appeals process to be cumbersome, complex and overly bureaucratic. Thus, problems with the complexity of our current health care system are by no means inherent only to government. So examining reform from the context of Medicare beneficiaries should consider whether more reliance on

private plans will only complicate and confuse beneficiaries further. An assumption is often made that using private plans to provide services will ease the government's oversight burdens, but at what expense to beneficiaries?

USING COMPETITION TO GENERATE SAVINGS

Reform options such as the premium support approach seek savings not only by relying on private plans but also on competition among those plans. Often this includes allowing the premiums paid by beneficiaries to vary such that those choosing higher cost plans pay substantially higher premiums. The theory is that beneficiaries will become more price conscious and choose lower cost plans. This in turn will reward those private insurers able to hold down costs. And there is some evidence from the federal employees system and the Calpers system in California that this has disciplined the insurance market to some degree in the 1990s. But the experiences in the last few years lend considerable doubt to that enthusiasm.

Studies that have focused on retirees, moreover, show much less sensitivity to price differences among older Americans. Older persons may be less willing to change doctors and learn new insurance rules in order to save a few dollars each month. Thus, what is not known is how well this will work for Medicare beneficiaries.

For example, for a competitive approach to work, at least some beneficiaries must be willing to shift plans each year (and to change providers and learn new rules) in order to reward the more efficient plans. Without that shifting, savings will not occur. In addition, there is the question of how private insurers will respond. (If new enrollees go into such plans each year, some savings will be achieved, but these are the least costly beneficiaries, and may lead to further problems as discussed below.) Will they seek to improve service or instead focus on marketing and other techniques to attract a desirable, healthy patient base? It simply isn't known if the competition will really do what it is supposed to do. In fact, undesirable outcomes may be as common as desirable ones.

New approaches to the delivery of health care under Medicare may generate a whole new set of problems, including problems in areas where Medicare is now working well. For example, shifting across plans is not necessarily good for patients; it is not only disruptive, it can raise costs of care. Studies have shown that having one physician over a long period of time reduces costs of care. And if it is only the healthier beneficiaries who choose to switch plans, the sickest and most vulnerable beneficiaries may end up being concentrated in plans that become increasingly expensive over time. The case of retirees left in the federal employees high-option Blue Cross plan and in a study of retirees in California suggest that even when plans become very expensive, beneficiaries may be fearful of switching and end up substantially disadvantaged.

Private plans should not be expected to meet larger social goals such as making sure that the sickest beneficiaries get high quality care if the financial incentives do not lead to such behavior. To the extent that such goals remain important, reforms in

Medicare will have to incorporate additional protections to balance these concerns as described below.

WHAT IT IS CRUCIAL TO RETAIN FROM MEDICARE

The reason to “save” Medicare is to retain for future generations the qualities of the program that are valued by Americans and that have served them well over the past 37 years. This means that any reform proposal ought to be judged on principles that go well beyond the savings that they might generate for the federal government.

I stress three crucial principles that are integrally related to Medicare’s role as a social insurance program:

- The universal nature of the program and its consequent redistributive function.
- The pooling of risks that Medicare has achieved to share the burdens across sick and healthy.
- The role of government in protecting the rights of beneficiaries--often referred to as its entitlement nature.

Although there are clearly other goals for and contributions of Medicare, these three are part of its essential core. Traditional Medicare, designed as a social insurance program, has done well in meeting these goals. What about options relying more on the private sector?

Universality and Redistribution

An essential characteristic of social insurance that Americans have long accepted is the sense that once the criterion for eligibility of contributing to the program has been met, that benefits will be available to all beneficiaries. One of Medicare’s great strengths has been providing much improved access to health care. Before Medicare’s passage, many elderly persons could not afford insurance, and others who could not obtain it were denied coverage as poor risks. That changed in 1966 and had a profound impact on the lives of millions of seniors. The desegregation of many hospitals occurred under Medicare’s watch. And although there is substantial variation in the ability of beneficiaries to supplement Medicare’s basic benefits, basic care is available to all who carry a Medicare card. Hospitals, physicians, and other providers largely accept the card without question.

Once on Medicare, enrollees no longer have to fear that illness or high medical expenses could lead to the loss of coverage--a problem that still happens too often in the private sector. This assurance is an extremely important benefit to many older Americans and persons with disabilities. Developing a major health problem is not grounds for losing the card; in fact, in the case of the disabled, it is grounds for coverage. This is vastly different than the philosophy of the private sector towards health coverage. Even though many private insurers are willing and able to care for Medicare patients, the easiest way to stay in business as an insurer is to seek out the healthy and avoid the sick. And in a market system, once that becomes the dominant approach, even insurers who

would like to treat sicker patients are penalized by the market if they do so. This can clearly be seen in the poor performance of the individual health insurance market in meeting the needs of persons in their early 60s.

Will reforms that lead to a greater reliance on the market still retain the emphasis on equal access to care and plans? For example, differential premiums could undermine some of the redistributive nature of the program that assures even low-income beneficiaries access to high quality care and responsive providers. Support for a market approach that moves away from a “one-size-fits-all” approach is a prescription for risk selection problems.

Perhaps of greatest concern is whether the dual eligibles who receive both Medicare and Medicaid continue to be treated as full Medicare beneficiaries. If, as some documents have indicated, the primary responsibility for these individuals will fall to Medicaid, the principle of universality will be undermined, and the most vulnerable seniors and persons with disabilities will be disenfranchised. States vary in their generosity and interest in this population. Further, people move in and out of Medicaid over time. How would they be treated by Medicare in those instances?

The Pooling Of Risks

One of Medicare’s important features is the achievement of a pooling of risks among the healthy and sick covered by the program. Even among the oldest of beneficiaries, there is a broad continuum across individuals’ needs for care. Although some of this distribution is totally unpredictable (because even people who have historically had few health problems can be stricken with catastrophic health expenses), a large portion of seniors and disabled persons have chronic problems known to be costly to treat. If these individuals can be identified and segregated, the costs of their care can expand beyond the ability of even well-off individuals to pay over time.

A major impetus for Medicare was the need to protect the most vulnerable. That’s why the program focused exclusively on the old in 1965 and then added the disabled in 1972. About one in every three Medicare beneficiaries has severe mental or physical health problems. In contrast, the healthy and relatively well-off (with incomes over \$32,000 per year for singles and \$40,000 per year for couples) make up less than 10 percent of the Medicare population. Consequently, anything that puts the sickest at greater risk relative to the healthy is out of sync with this basic tenet of Medicare. A key test of any reform should be who it best serves.

If the advantages of one large risk pool (such as the traditional Medicare program) are eliminated, other means will have to be found to make sure that insurers cannot find ways to serve only the healthy population. Although this very difficult challenge has been studied extensively; as yet no satisfactory risk adjustor has been developed. What has been developed to a finer degree, however, are marketing tools and mechanisms to select risks. High-quality plans that attract people with extensive health care needs are likely to be more expensive than plans that focus on serving the relatively healthy. If risk adjustors are never powerful enough to eliminate these distinctions and level the playing

field, then those with health problems, who also disproportionately have lower incomes, would have to pay the highest prices under many reform schemes.

On the other hand, it does not seem to be wise policy in a period of resource scarcity to pay private plans more than is available to traditional Medicare to participate. Some outlier payment or risk adjustment might be used to help encourage plans to come into the program, but a flat, across-the-board payment addition is unsound policy and unfair to those remaining in traditional Medicare.

The Role of Government

Related to the two above principles is the role that government has played in protecting beneficiaries. In traditional Medicare, this has meant having rules that apply consistently to individuals and assure that everyone in the program access to care. It has sometimes fallen short in terms of the variations that occur around the country in benefits, in part because of interpretation of coverage decisions but also because of differences in the practice of medicine. For example, rates of hospitalization, frequency of operations such as hysterectomies, and access to new tests and procedures vary widely by residence, race and other characteristics. But in general, Medicare has to meet substantial standards and accountability that protect its beneficiaries.

If the day-to-day provision of care is left to the oversight of private insurers, what will be the impact on beneficiaries? It is not clear whether the government will be able to provide sufficient oversight to protect beneficiaries and assure them of access to high-quality care. If an independent board -- which is part of many restructuring proposals -- is established to negotiate with plans and oversee their performance, to whom will it be accountable? Further, what provisions will be in place to step in when plans fail to meet requirements or who leave an area abruptly? What recourse will patients have when they are denied care? The need for this oversight will likely add to administrative costs; if not, beneficiaries will suffer. At present Medicare pays only 30 cents per beneficiary annually for the state counseling programs to answer questions from beneficiaries. That already inadequate budget needs to be expanded by a factor of ten or more in the type of environment anticipated.

ASSESSING THE PROMISED ADVANTAGES OF PRIVATE SECTOR APPROACHES

A number of advantages in addition to holding the line on costs are also often put forth to generate support for this type of approach. A private approach has the potential to reduce the role in government of “micromanaging” health care, often expressed as no more price fixing by government and greater flexibility for innovation and change in coverage of benefits. But even more frequently, this approach is emphasized as a means for moving away from a “one size fits all” approach to insurance. In practice, however, some of these claims are likely to interfere with the functioning of effective competition aimed at holding down the costs of care. Tradeoffs will undoubtedly need to be made.

Choice

While choice and avoidance of uniformity is an appealing promise, it is important to examine exactly what that means. Many people have made the point that most beneficiaries want choice of providers of care—doctors and hospitals. They care much less about whether it is Aetna or Cigna that provides the insurance. (Actually, that may turn out to be quite short-sighted if plans vary in terms of the details of operations, such as how much they will pay for services when someone goes out of network. But those considerations are hard to build into a choice model since even aggressive consumers find it difficult to obtain such information.)

But the appeal for choice of plan is usually made on the argument that people will be able to get only the coverage they want and need, even if they have to pay a little more. The difficulty is that without standardization of the most important benefits, such choice will lead to risk selection. Young healthy 65 year olds will pass on home health coverage, for example, in exchange for other benefits or a lower premium. But until risk adjusters get much better (if ever), standardization is important. Moreover, to get plans to compete on price, consumers must be able to compare plans—another strong argument for standardization. It is not possible to realistically expect both variation in options and health competition.

Flexibility, Innovation and Oversight

One of the advantages touted for private plans is their ability to be flexible and even arbitrary in making decisions. This allows private insurers to respond more quickly than a large government program can and to intervene where insurers believe too much care is being delivered. But what looks like cost-effectiveness activities from an insurer's perspective may be seen by a beneficiary as the loss of potentially essential care. Which is more alarming: too much care or care denied that cannot be corrected later? Some of the “inefficiencies” in the health care system may be viewed as a reasonable response to uncertainty when the costs of doing too little can be very high indeed. This arbitrariness also means that providers can be dropped from a plan with little notice, potentially adding to disruptions for beneficiaries.

The need for strong government oversight will not go away under a private plan approach unless there are to be few beneficiary protections. Many insurers do not have a good track record in this area, for example. Patient problems and complaints under the Medicare+Choice option underscore the need to offer appeals rights, oversight and sometimes direct intervention in order to protect beneficiaries. For example, at present when plans are found to be inappropriately denying care to beneficiaries, the corrections are done on a case-by-case basis even after the same plan in the same area has been told multiple times to cover a particular service. If private plans are to be even more widespread, this will require a great deal of attention and effort.

Considerable investment in information and education would be needed—spending that goes well beyond what Congress has been willing to commit thus far. Information about plans should not be left solely to the responsibility of the plans themselves.

Unfortunately, there are too few examples of truly innovative new techniques, organizational strategies or other contributions from private plan competition. Many managed care plans, for example, have relied on price discounts and do not even have the data and administrative mechanisms to attempt any care coordination. And preferred provider organizations—the newest private form to be hailed as an improvement—rely not only on price discounts but on passing off very high costs to beneficiaries who choose to go out of network for their care. Here the misconception is that you can see any care provider you wish. That’s true for those with substantial resources but not for the vast majority of Medicare beneficiaries who have only modest incomes. And as the recent CMS report suggests, the main mechanism PPOs have to control use of services is to drop providers deemed to be ordering too many services. At best, this is a crude adjustment device.

If innovation is a major reason for relying on private plans, it may make most sense to provide incentives for plans to specialize and take on those with high risks or particular conditions. This is where innovation is needed and where care coordination potentially offers the greatest payoffs.

Avoiding Price Setting

Moving away from traditional Medicare will not eliminate the issue of administered prices in health care. There is no free market where doctors and plans negotiate openly on rates. In fact, many private plans use at least some aspect of Medicare payment systems in setting their rates. In a world of many private insurers, the likely result is hundreds of administered prices being set for each service by each plan.

In an industry like health care where there are many examples of “market failure” (because of concentrated power, lack of good information and knowledge, product differentiation), the workings of supply and demand can lead to perverse results. For example, competing hospitals in a given area result in over-capacity as each hospital tries to have all the latest equipment to attract doctors and patients. As already mentioned, plans will tend to compete to attract healthy patients rather than to develop the best management and care coordination protocols. And yes, price setting is and will continue to be a part of the private insurance world as well as within Medicare.

CHANGES TO IMPROVE MEDICARE

Making changes to Medicare that can improve its viability both in terms of its costs and in how well it serves older and disabled beneficiaries should certainly be pursued. Further, it makes little sense to look for a solution that takes policy makers permanently out of Medicare’s future. The flux and complexity of our healthcare system will necessitate continuing attention to this program. At present a number of areas in Medicare need attention. No reform plan can be considered adequate if it ignores traditional Medicare.

What are the tradeoffs from increasingly relying on private plans to serve Medicare beneficiaries? The modest gains in lower costs that are likely to come from some increased competition and from the flexibility that the private sector enjoys could be more than offset by the loss of social insurance protection. The effort necessary to create in a private plan environment all the protections needed to compensate for moving away from traditional Medicare will be very challenging and cannot promise success. For example, even after six years, many of the provisions in the Balanced Budget Act of 1997 that would be essential in any further moves to emphasize private insurance--generating new ways of paying private plans, improving risk adjustment, and developing information for beneficiaries, for example--still need a lot of work.

In addition, it is not clear that there is a full appreciation by policymakers or the public at large of all the consequences of a competitive market. Choice among competing plans and the discipline that such competition can bring to prices and innovation are often stressed as potential advantages of relying on private plans for serving the Medicare population. But if there is to be choice and competition, some plans will not do well in a particular market, and as a result they will leave. In fact, if no plans ever left, that would likely be a sign that competition was not working well. But plan withdrawals will result in disruptions and complaints by beneficiaries--much like those that have occurred with the withdrawals from Medicare+Choice. Beneficiaries must then find another private plan or return to traditional Medicare. They may have to choose new doctors and learn new rules. This situation has led to politically charged discussions about payment levels in the program even though that is only one of many factors that may cause plans to withdraw. Thus, not only will beneficiaries be unhappy, but there may be strong political pressure to keep federal payments higher than a well functioning market would require.

What I would prefer to see instead is emphasis on improvements in *both* the private plan options and the traditional Medicare program, basically retaining the current structure in which traditional Medicare is the primary option. Rather than focusing on restructuring Medicare to emphasize private insurance, I would place the emphasis on innovations necessary for improvements in health care delivery regardless of setting.

Critics of Medicare rightly point out that the inadequacy of its benefit package has led to the development of a variety of supplemental insurance arrangements which in turn create an inefficient system in which most beneficiaries rely on two sources of insurance to meet their needs. It is sometimes argued that improvements in coverage can only occur in combination with structural reform. And some advocates of a private approach to insurance go further, suggesting that the structural reform itself will naturally produce such benefit improvements. This implicitly holds the debate on improved benefits hostage to accepting other unrelated changes. That logic actually should run in the other direction. It is not reasonable to expect any number of other changes to work without first offering a more comprehensive benefit package for Medicare. In that way, payments made to private plans can improve, allowing them to better coordinate care. And the fee for service system will also be able to change in ways that might encourage better care delivery. For example, it is not reasonable to ask patients to participate in a

program to reduce hypertension (which can save costs over the long run) without covering the prescription drugs that are likely to be an essential part of that effort. In addition, a better benefit package will also allow at least some beneficiaries to forego the purchase of inefficient private supplemental insurance. That itself should be a goal of reform.

In addition, better norms and standards of care are needed if we are to provide quality of care protections to all Americans. Investment in outcomes research, disease management and other techniques that could lead to improvements in treatment of patients will require a substantial public commitment. This cannot be done as well in a proprietary, for-profit environment where dissemination of new ways of coordinating care may not be shared.

Private plans can play an important role and may develop some innovations on their own, but in much the same way that we view basic research on medicine as requiring a public component, innovations in health delivery also need such support. Further, innovations in treatment and coordination of care should focus on those with substantial health problems -- exactly the population that many private plans seek to avoid. Some private plans might be willing to specialize in individuals with specific needs, but this is not going to happen if the environment is one emphasizing price competition and with barely adequate risk adjusters. Innovative plans would likely suffer in that environment. This is where I recommend work to enhance the effectiveness of private plans. Further, Finally, the default plan--where those who do not or cannot choose or who find a hostile environment in the world of competition--must, at least for the time being, be traditional Medicare. Thus, there needs to be a strong commitment to maintaining a traditional Medicare program while seeking to define the appropriate role for alternative options.

A good area to begin improvements in knowledge about the effectiveness of medical care would be with prescription drugs. Realistically, any prescription drug benefit will require efforts to hold down costs over time. Part of that effort needs to be based on evidence of the comparative effectiveness of various drugs, for example. Establishing rules for coverage of drugs should reflect good medical evidence and not just on which manufacturer offers the best discounts. Undertaking these studies and evaluations represents a public good and needs to be funded on that basis.

Within the fee-for-service environment, it would be helpful to energize both patients and physicians in helping to coordinate care. Patients need information and support as well as incentives to become involved. Many caring physicians, who have often resented the low pay in fee for service and the lack of control in managed care, would likely welcome the ability to spend more time with their patients. One simple way to do this would be to give beneficiaries a certificate that spells out the care consultation benefits to which they are entitled and allow them to designate a physician who will provide those services. In that way, both the patient and the physician (who would get an additional payment for the annual or biannual services) would know what they are expected to provide and could likely reduce confusion and unnecessary duplication of

services that go on in a fee for service environment. This change should be just one of many in seeking to improve care coordination.

Additional flexibility to CMS to manage and develop payment initiatives aimed at using competition where appropriate also could result in long term cost savings and serve patients well. In the areas of durable medical equipment and perhaps even some testing and laboratory services, contracting could be used to obtain favorable prices.

These are only a few examples of changes, none of which promise to be the magic bullet, but which could aid the Medicare program over time.